

PCMH Payer Subcommittee Meeting
November 10, 2014

Attendees

Dr. Pat Morrow, Blue Cross Blue Shield of Montana
Jo Thompson, Medicaid
Mary LeMieux, Medicaid
Dr. Jonathan Weisul, Allegiance
Dr. Tom Roberts, MT Health Co-op
Todd Lovshin, PacificSource

CSI Staff

Amanda Eby

CSI staff explained that the payer rule had been filed including the language that they unanimously agreed on at the last meeting. Staff was now looking to the subcommittee for guidance in developing reporting instructions for the payer utilization measures. Each payer shared their individual perspective on utilization reporting and technological capabilities.

Dr. Morrow asked if the entire member population would also include the PCMH population. Amanda said yes, but they should confirm that with Dr. Berner.

Dr. Weisul checked with the IT people at Allegiance on reporting capabilities and they said they could do the reporting in the way prescribed but would need rules for what constitutes a PCMH patient, and how that patient is attributed to a PCMH.

CSI staff clarified that payers would only be required to report on patients they attribute to PCMHs they contract with, not every PCMH. Dr. Weisul raised concerns about the utilization data only tracking practices with the ability to contract with payers and leaving a large hole of FQHCs and others not receiving payment. Jo thought it would be much easier as a payer to report data only on patients at PCMHs that they contract with.

CSI staff explained that although there may be holes in data that doesn't include PCMHs that aren't in payer contracts, the data would be more accurate because it is a defined population.

Todd said PacificSource could do either type of reporting since they require a (Primary Care Physician) PCP declaration from all their members. Dr. Morrow said BCBS can report ER visits and hospitalization rates in aggregate form for their entire population and for the subset of attributed PCMH members.

Dr. Weisul asked what timeframe the data is supposed to be from, which posed several questions and reporting possibilities. Attendees discussed how to account for "churning" or patients moving between insurers and providers and prevent them from getting counted in the utilization report multiple times. They wondered how much (minimum) of the year a patient should be attributed to a PCMH for their

utilization to go on the PCMH list – and alternatively for “non-PCMH patients.” Dr. Weisul said Allegiance would not be able to have their IT people differentiate between when patients move from a PCMH to a non-PCMH.

The group decided that for this first year, the utilization data report will be a “snapshot” pull of data on a particular day, such as December 31, 2014, and will include patients that are attributed on that day. The group agreed unanimously to move forward with this approach. The “snapshot” date is a starting point. We still need to determine how to attribute somebody and whether to “count” them if they’ve only been in the PCMH for a short time.

Jo asked if they would count every ER visit or just one if “Johnny” visits once and then has a follow-up visit to the ER. The group agreed unanimously to count every ER visit because every visit costs money.

The subcommittee will potentially have a longer meeting in December to finishing developing the reporting guidance. Subcommittee member should brainstorm additional questions that need to be answered in the guidance in advance of the meeting.